

**CONTACT MEMORANDUM**  
**FOR PROVISION OF SERVICES TO TENNCARE ENROLLEES**

**Information for Providers:** TennCare intends to issue RFPs to secure contracts with managed care organizations (MCOs) for the provision of integrated behavioral health and physical health services on a full-risk basis in the East and West Grand Regions of Tennessee. As part of the responses to the RFPs, the State will require proposers to submit "Contact Memorandums" for certain provider types/services. Contact Memorandums will be used to demonstrate to the State that the proposer has contacted a specified number of providers for selected provider types/services (see list below) and has actively engaged in discussions with them. A Contact Memorandum is not a binding agreement. Also, it shall not prevent a provider from talking with other proposers or impact the provider's relationship with existing MCOs. For additional information please see the "Notice of Intent to Issue RFPs for MCOs Serving East and West Grand Regions," which is available on the TennCare website ([www.tennessee.gov/tenncare/](http://www.tennessee.gov/tenncare/)).

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By signing this Contact Memorandum, you (the provider) acknowledge that you have been contacted by [proposer's name] and have discussed the items checked "Yes" below: [If the item was not discussed, check "No"; if the item is not applicable, check "N/A"]

- |   |                              |                             |                              |
|---|------------------------------|-----------------------------|------------------------------|
| a. Services that you offer  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| b. Whether you provide services to adults and/or children   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| c. Counties served by you/your service sites  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| d. Whether you are located in-state or out-of-state   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| e. Hospitals with which you are affiliated or have an admitting arrangement   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| f. Language(s) spoken by you and any interpreter services that are available at your office/facility                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| g. Whether you are currently a TennCare provider and whether you have a NPI number and/or TennCare Medicaid identification number | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| h. Whether you are currently contracted with a TennCare MCO   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| i. Number of TennCare patients you are seeing   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                              |
| j. Your referral patterns (what providers you make referrals to and what providers you get referrals from)                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |

By signing this Contact Memorandum, [proposer's name] attests that it has contacted the provider identified below and has discussed the items checked "Yes" above.

**1. PROVIDER'S PRINTED NAME**

\_\_\_\_\_

**2. PROVIDER TYPE/SERVICES (check all that apply)**

- a. Alcohol and Drug (A&D) Services ☐
- b. Community Mental Health Agency (CMHA) ☐
- c. Hospital ☐
- d. Local Health Department (LHD) ☐
- e. Prenatal Care Services ☐
- f. Primary Care Provider (PCP) ☐
- g. Private Duty Nursing/Home Health Services ☐
- h. Psychiatrist (other than CMHA) ☐
- i. Psychologist (other than CMHA) ☐
- j. Regional Mental Health Institute (RMHI)/Private Hospital ☐

**3. PROVIDER/PROVIDER REPRESENTATIVE'S SIGNATURE**

\_\_\_\_\_ **DATE** \_\_\_\_\_

**4. PRINTED NAME OF SIGNER FOR PROVIDER**

\_\_\_\_\_

**5. TITLE OF SIGNER FOR PROVIDER**

\_\_\_\_\_

**6. PROPOSER REPRESENTATIVE'S SIGNATURE**

\_\_\_\_\_ **DATE** \_\_\_\_\_

**7. PRINTED NAME OF PROPOSER REPRESENTATIVE**

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**8. TITLE OF SIGNER FOR PROPOSER**

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